

Notice of Second Qualifying Event

(Form and Notice Procedures)

This form, including the “Procedures for Notice of Second Qualifying Event” section, is part of the *PEBB Initial Notice of COBRA and Continuation Coverage Rights* booklet. For more information about this form, the PEBB’s notice procedures, and your COBRA rights and obligations, consult the *PEBB Summary Plan Description of Continuation Coverage Rights Under COBRA and PEBB Rules*, and other sections of the *PEBB Initial Notice of COBRA and Continuation Coverage Rights*. These documents are available by calling PEBB Benefit Services at 1-800-200-1004.

When to use this form

An extension of coverage may be available to spouses, qualified same-sex domestic partners, and dependent children who are receiving continuation coverage if a second qualifying event occurs during the 18 months (or, in the case of a disability extension or for some LWOP coverage enrollees, 29 months) following the covered employee’s termination of employment or reduction of hours. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months.

Use this form when any of the following events (second qualifying events) occurs:

- A spouse who is receiving PEBB continuation coverage becomes divorced or legally separated from the covered employee;
- Dissolution of a qualified same-sex domestic partnership;
- A child who is receiving PEBB continuation coverage is no longer eligible under PEBB rules (as set forth in chapter 182-12 of the Washington Administrative Code [WAC]); or
- The covered employee dies while one or more qualified beneficiaries are receiving COBRA or other continuation coverage.

Deadline

The deadline for providing this notice is **60 days** after the latter of:

- The date of the second qualifying event (i.e., divorce, legal separation, dissolution of a qualified same-sex domestic partnership, the covered employee’s death, or a child’s loss of dependent status); or
- The date the covered spouse, qualified same-sex domestic partner, or dependent child would lose PEBB coverage as a result of the second qualifying event (if this event had occurred while the qualified beneficiary was still covered under PEBB coverage).

If your notice is late, or if it is not completed and provided to PEBB Benefit Services as described in the “Procedures for Notice of Second Qualifying Event” section, no beneficiary will be offered the opportunity to elect extended COBRA or other continuation coverage.

Procedures for Notice of Second Qualifying Event

How to provide notice

Your notice **must** be in writing (using the PEBB form included in this notice) and either mailed or hand-delivered. Oral notice (in person or by telephone) and electronic notice (fax or e-mail) is not acceptable.

If mailed, your notice must be postmarked no later than the deadline described in these procedures. If hand-delivered, your notice must be received by PEBB Benefit Services at the address below no later than the deadline described in these procedures.

Mailing address

Health Care Authority
PEBB Benefit Services
P.O. Box 42684
Olympia, WA 98504-2684

Street address (for hand deliveries)

Health Care Authority
PEBB Benefit Services
676 Woodland Square Loop SE
Lacey, WA 98503

Required form and information

You **must** use the *Notice of Second Qualifying Event (Form and Notice Procedures)* form to notify PEBB Benefit Services of a second qualifying event (i.e., a divorce, legal separation, dissolution of a qualified same-sex domestic partnership, the covered employee's death, or a child's loss of dependent status). All of the applicable items on the form must be completed.

If you are notifying PEBB Benefit Services of a **divorce or legal separation**, you must also include a copy of the decree of divorce or legal separation.

If you are notifying PEBB Benefit Services of the **dissolution of a qualified same-sex domestic partnership**, you must also include the date the same-sex domestic partner ceased to meet PEBB eligibility as set forth in the *Declaration of Marriage or Same-Sex Domestic Partnership* form.

Incomplete notice

If you provide a written notice that does not contain all of the information and documentation required by these notice procedures, such a notice will nevertheless be considered timely only if **all** of the following conditions are met:

- The notice is mailed or hand-delivered to PEBB Benefit Services at the address specified in these notice procedures;
- The notice is provided by the deadline described in this document;
- From the written notice provided, PEBB Benefit Services is able to determine that the notice relates to PEBB coverage;
- From the written notice provided, PEBB Benefit Services is able to identify the covered employee and qualified beneficiary(ies), the first qualifying event (the covered employee's termination of employment or reduction of hours), the date the first qualifying event occurred, the second qualifying event, and the date the second qualifying occurred; and
- The additional information and documentation necessary to meet PEBB requirements (as described in these notice procedures) is provided in writing within **15 business days** after a written or oral request from PEBB Benefit Services for more information (or, if later, by the deadline for the notice of second qualifying event described above).

If any of these conditions are not met, the incomplete notice will be rejected and COBRA or other continuation coverage will not be extended. If all of these conditions are met, PEBB Benefit Services will treat the notice as having been provided on time.

Who may provide notice

The employee or former employee who is or was covered under PEBB coverage, a qualified beneficiary who lost coverage due to the covered employee's termination of employment or reduction of hours and is still receiving COBRA or other continuation coverage, or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who may be entitled to an extension of the maximum COBRA, PEBB Extension of Coverage, or Leave Without Pay (LWOP) coverage period due to the second qualifying event described in the notice.

Additional evidence of the date of a child's loss of dependent status may be required

If your notice was regarding a child's loss of dependent status, and PEBB Benefit Services requests it, you **must** provide satisfactory documentation of the date of the qualifying event within **15 business days**. For example, this could include a birth certificate to establish the date that a child reached the limiting age, a marriage certificate to establish the date that a child married, or a transcript or other satisfactory evidence showing the last date of enrollment in an educational institution. This will allow PEBB Benefit Services to determine if you gave timely notice of the second qualifying event, and were consequently entitled to an extension of continuation coverage.

If you do not provide satisfactory evidence within this timeframe after a written or oral request from PEBB Benefit Services, the child's continuation coverage may be terminated (retroactively if applicable) as of the date that COBRA or other continuation coverage would have ended without an extension due to loss of dependent status.

The Health Care Authority (HCA) will require repayment to the health plan of all benefits paid after the termination date.

Additional evidence of the date of the covered employee's death may be required

If your notice was regarding the death of the covered employee, upon request of PEBB Benefit Services, you **must** provide satisfactory documentation of the date of death within **15 business days** (for example, a death certificate or published obituary). This will allow PEBB Benefit Services to determine if you gave timely notice of the second qualifying event, and were consequently entitled to an extension of COBRA or other continuation coverage.

If you do not provide satisfactory evidence within this timeframe after a written or oral request from PEBB Benefit Services, the qualified beneficiaries' continuation coverage may be terminated (retroactively if applicable) as of the date that COBRA, PEBB Extension of Coverage, or Leave Without Pay (LWOP) coverage would have ended without an extension due to the covered employee's death.

The Health Care Authority (HCA) will require repayment to the health plan of all benefits paid after the termination date.

Notice of Second Qualifying Event

Type or print clearly in black ink.

Identify the employee or retiree who was covered under PEBB coverage

Print name of employee	Social security number
Print name of retiree	Social security number
Address of employee or retiree	

Identify the initial qualifying event

- ☐ **Termination of employment**
- ☐ **Reduction of hours**
- ☐ **Leave Without Pay (LWOP)**
Loss of employee eligibility for employer coverage due to one of the following:
 - Authorized leave without pay (LWOP) from employing agency;
 - Layoff because of a reduction in force (RIF);
 - Receipt of time-loss benefits under workers' compensation;
 - Application for disability retirement;
 - Call to active military duty (employees called to active military duty may only continue PEBB life insurance for 12 months);
 - Approved educational leave (employees on educational leave may continue long-term disability for a maximum of 24 months);
 - Part-time faculty member between periods of eligibility (see WAC 182-12-133(2)); or
 - Employee reverted and was not eligible for employer-paid benefits (see WAC 182-12-141).
- ☐ **Extension of Coverage**
Loss of retiree eligibility due to one of the following:
 - Employer group terminated PEBB plan participation; or
 - Retiree was determined no longer disabled by the Department of Retirement Systems and stopped receiving a retirement pension.

Identify all qualified beneficiaries

Print name(s) of all qualified beneficiaries who lost coverage due to the initial qualifying event who are still receiving continuation coverage.

Is the address of each qualified beneficiary the same as the employee or retiree? ☐ Yes ☐ No If different, provide address below:

(continued on next page)

Identify second qualifying event (check one and complete)

☐ **Employee and spouse or qualified same-sex domestic partner:**

☐ Divorced

☐ Legally separated

☐ Dissolved the qualified same-sex domestic partnership

Print name of spouse or same-sex domestic partner _____

Date of divorce, legal separation, or dissolution of partnership (A copy of the decree of divorce or legal separation is required.) _____

Address of spouse or same-sex domestic partner _____

☐ **Child ceased to be an eligible dependent under PEBB rules**

Reason:

☐ Attained age that is no longer eligible for PEBB coverage

☐ Loss of student status

☐ Loss of dependent status through divorce, legal separation, or dissolution of qualified same-sex domestic partnership

☐ Married

☐ Other _____

Print name of child _____

Date of event which caused loss of dependent eligibility _____

Address of child if different than employee or retiree _____

☐ **Death of employee or retiree**

Date of employee's or retiree's death _____

Certification, signature, and date

I certify that the above information is true and correct.

I am the (check one): ☐ Former employee or retiree

☐ Spouse or former spouse

☐ Qualified same-sex domestic partner or former qualified same-sex domestic partner

☐ Former dependent child of a qualified same-sex domestic partner

☐ Former dependent child

☐ Other (explain) _____

Signature _____

Date _____

Print name _____

Telephone number
() _____

Address _____

Please sign and date this form.

Return to: Washington State Health Care Authority, PEBB Benefit Services, P.O. Box 42684, Olympia, WA 98504-2684

Washington State law may require disclosure of any information you submit as a public record.
The HCA's Privacy Notice is available upon request by calling 360-923-2822 or online at www.hca.wa.gov.

Visit our Web site at www.pebb.hca.wa.gov

For HCA Use Only

Date notice of second qualifying event received _____ Date of postmark, if mailed _____

Decree of divorce or legal separation enclosed? ☐ Yes ☐ No ☐ N/A